North Carolina Department of Health and Human Services
Division of Public Health / Women's and Children's Health Section

CHILD SERVICE COORDINATION PROGRAM
IDENTIFICATION AND REFERRAL

1. Last Name First Name MI

2. Patient Number: H

3. Date of Birth: Month Day 19 Year

4. Race: 1 = White 2 = Black 3 = Am. Ind./Alaskan Native 4 = Asian/Pacific Islander

5. Ethnicity: Hispanic Origin? 1 = Yes 2 = No

6. Special Populations:
Migrant Farmworker/Dependent? (Y/N)
Seasonal Farmworker/Dependent? (Y/N)
English Speaking? (Y/N)
Homeless? (Y/N)
Refugee? (Y/N)
Country of Origin:
1=Mexico
2=Haiti
9=Other – All others including USA

7. Sex: 1 = Male 2 = Female

8. County of Residence: _____

9. Child Has: Medicaid? (Y/N)
Other Insurance? (Y/N)
Self-Pay? (Y/N)
Medicare? (Y/N)

10. Designated CSC Agency:
_____
_____

11. Date Identification and Referral form completed: Month Day Year

12. Referral Source: *(Please Print)*
Name _____
Agency _____
Address _____
_____
Telephone Number _____

13. Parental Information: *(If parent is not legal guardian, list who has legal custody and how they can be contacted.)*
Name: _____
Telephone No. of Parent/Guardian: (____) _____
Home Address: _____
_____
Directions to Home: _____
_____
_____
_____

14. Date Information and Referral form received by Health Department: Month Day Year

15. Risk Conditions: (Circle the code number of each condition identified. Refer to Child Service Coordination Manual for definitions.)

PARENTAL/FAMILY CONDITIONS
100 Maternal age <15 years
101 Maternal PKU
102 Mother HIV positive
103 Maternal use of anticonvulsant, anti-neoplastic or anticoagulant drugs
104 Parental blindness
105 Parental substance abuse
106 Parental mental retardation
107 Parental mental illness
108 Difficulty in parent-infant bonding
109 Difficulty in providing basic parenting
110 Lack of stable housing
111 Lack of familial and social support
112 Family history of childhood deafness
113 Maternal Hepatitis B
114 MOW
115 History of abuse or neglect of parent

NEONATAL CONDITIONS
200 Birth weight <1500 grams *
201 Gestational age <32 weeks *
202 Respiratory distress (mechanical ventilator >6 hours)
203 Asphyxia
204 Hypoglycemia (<25 mg/dl)
205 Hyperbilirubinemia (>20 mg/dl)
206 Intracranial hemorrhage *
207 Neonatal seizures *

* Review I-TP Eligibility

POSTNEONATAL CONDITIONS
300 Suspected visual impairment
301 Suspected hearing impairment
302 No well child care by age 6 months
303 Failure on standard developmental or sensory screening test
304 Significant parental concerns
305 Suspected abuse/neglect
306 Chronic lung disease *

DIAGNOSED CONDITIONS
400 Potential high risk
401 Developmental delay *
402 Atypical development *
403 Chromosomal anomaly/genetic disorder *
404 Metabolic disorder
405 Infectious disease *
406 Neurologic disease *
407 Congenital malformation
409 Toxic exposure
410 Vision disorder *
411 Hearing disorder *

16. Child's Primary Medical Provider:
Name _____
Address _____
_____
_____
Telephone Number _____

17. Referrals: (Check all referrals requested by the family and made at this time or check no referrals block.) ☐ No referrals at this time
___ Nursing Services
___ Social Work Services
___ Parent Support Programs
___ **BEGINNINGS** Referral
___ Physical Therapy
___ Vision Services
___ Medical (Evaluation) Services
___ Deaf/HH Interpreter/Transliterator
___ Transportation
___ Special Instruction – Home
___ Genetic Services
___ Preschool/Program (Part B)
___ Financial Assistance
___ Alternative Residential Placement
___ Family Counseling and Therapy
___ Supplemental Security Income
___ Before and After School – Summer Care
___ Non-English Interpreter/Translator
___ Psychological Services
___ Health (Chronic/Acute) Services
___ Immunizations
___ Occupational Therapy
___ Audiological Services
___ Child Service Coordination
___ Speech-Language Therapy
___ Assistive Technology
___ Well Child Care
___ Housing
___ Special Instruction – Center
___ WIC Program Services
___ Multidisciplinary Evaluation and Assessment
___ Nutrition Services
___ In-Home Support
___ Respite Care
___ Child Care
___ Other; specify _____

18. Parent has been informed about Child Service Coordination? ☐ Yes ☐ No

PURPOSE: To identify and refer children to the Child Service Coordination Program and to collect information on their risk conditions.

PREPARATION: Hospital – This form is to be completed by hospital personnel or public health nurses assigned responsibility for identifying and referring children to the Child Service Coordination Program. Items that are shaded are to be completed by the health department in the county where the child resides.

Post-Discharge – This form is to be completed by the professional who refers the child to the Child Service Coordination Program. Items that are shaded are to be completed by the health department in the county where the child resides.

DISTRIBUTION: COMPLETED IDENTIFICATION AND REFERRAL forms are forwarded to the health department in the county where the child resides.

INSTRUCTIONS: Numbers correspond to item numbers on the front of this form.

1. **Patient's Name:** Enter last name, first name and middle initial.
2. **Patient Number:** Enter the child's HSIS or temporary identification number. To be entered by the health department in the county where the child resides.
3. **Date of Birth:** Enter the child's eight-digit date of birth, e.g., May 1, 1993 = 0 5 0 1 1 9 9 3.
4. **Race:** Enter the code number that corresponds to the child's race, e.g., black = 2. If there is no appropriate code for child's race, enter code for mother's race.
5. **Ethnicity:** Enter the code that indicates whether the primary culture of the child's home/family is Hispanic, e.g., Yes = 1.
6. **Special Populations**: Respond Y or N to all items in the left column. Country of origin requires: 1=Mexico, 2=Haiti or 9=All others including USA.
7. **Sex:** Enter the code number that corresponds to the child's sex,. e.g., male = 1.
8. **County of Residence:** Write in the name of the county where the child's family resides. The health department in the county of residence enters the three-character code for the county of residence. Refer to Child Service Coordination Program Manual.
9. **Child has Medicaid, Other Insurance, Self-Pay, or Medicare:** Respond Y or N to each category.
10. **Designated Service Coordination Agency:** Enter name of agency. Health department confirms designation and enters agency code.
11. **Information and Referral Completion Date:** Referral source enters the date the form was completed using the six-digit date, e.g. May 1, 1993 = 0 5 0 1 9 3.
12. **Referral Source:** Print the name, agency, address, and telephone number of the person referring the child to the Child Service Coordination Program.
13. **Parental Information:** Enter the name, telephone number, address, and directions to home.
14. **Information and Referral Receipt Date:** The health department enters the date the completed Information and Referral form is received using the six-digit date, e.g. May 1, 1993 = 0 5 0 1 9 3.
15. **Risk Conditions:** Circle the code number of each risk condition identified. Refer to Child Service Coordination Manual for definitions.
16. **Child's Primary Medical Provider:** Enter name, address, and telephone number of child's primary medical provider, if known.
17. **Referrals:** Check all referrals requested by the family and made at this time or check no referrals block. Each service is defined in Bulletin No. 15 of the Infant-Toddler Program Manual.
18. **Parent has been informed about Child Service Coordination:** Check appropriate response.

DISPOSITION: This form may be destroyed in accordance with the Programs Operational Records Standard of the *Records Disposition Schedule* published by the North Carolina Division of Archives and History.

REORDER INFORMATION: Additional copies may be ordered on the REQUISITION FOR CHILDREN AND YOUTH MATERIALS (DHHS 3526) from:

N.C. Department of Health and Human Services
Division of Public Health/Women's and Children's Services Section
Children and Youth Branch
1916 Mail Service Center
Raleigh, NC 27699-1916